STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 07/18/2012				
		155636	B. WIN			07/18/	ZU 1Z
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HARRISC	ON TERRACE				ELLESLEY BLVD APOLIS, IN 46219		
			1	<u> </u>	Al OLIO, III 40213		710
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
F0000		,					
	This visit was for	r the Investigation of	F00	00			
	Complaint IN00	111520.					
	Complaint IN00	111520 - Substantiated.					
	Federal/State def	ficiencies related to the					
	allegations are ci	ted at F323 and F469.					
	Survey dates: Ju	ıly 17 & 18, 2012					
	Facility number:						
	Provider number	155636					
	AIM number: 10	00291310					
	Survey Team:						
	Rita Mullen, RN	TC					
	Michelle Carter,	RN					
	Census bed type:	:					
	SNF/NF: 109						
	Total: 109						
	Census payor typ	pe:					
	Medicare: 8						
	Medicaid: 93						
	Other: 8						
	Total: 109						
	Sample: 3						
		es also reflect state					
	_	accordance with 410 IAC					
	16.2.						
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURI	I	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155636	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 07/18	
NAME OF F	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP COE ELLESLEY BLVD	DE	
HARRIS	ON TERRACE			APOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	Quality review 7	7/20/12 by Suzanne				

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Event ID: GQOW11 Facility ID: 000241

If continuation sheet Page 2 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			ONSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155636	B. WIN			07/18/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ELLESLEY BLVD		
HADDISC	ON TERRACE				APOLIS, IN 46219		
HARRISC	JN TERRACE			INDIAN	APOLIS, IN 402 19		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323	483.25(h)					·	
SS=D	FREE OF ACCID						
		RVISION/DEVICES					
	_	ensure that the resident					
		ains as free of accident					
	•	sible; and each resident					
		e supervision and					
		es to prevent accidents.	F02	22	The second second second	£	00/04/2012
		review and interview, the	F03	25	The creation and submission of this Plan of Correction does no		08/04/2012
		monitor and supervise a			this Plan of Correction does no constitute an admission by	Jι	
	resident with der	nentia, who was given a			Harrison Terrace of any		
	bag of dry dog fo	ood for her stuffed toy			conclusion set forth in the		
		a possible consumption			statement of deficiencies, or of	:	
		by the resident. This			any violation of regulation.		
					Harrison Terrace respectfully		
	•	residents reviewed for			requests that this 2567 Plan of	:	
	•	e sample of 3. (Resident			Correction be considered the		
	B)				Letter of Credible Allegation of		
					Compliance. Harrison Terrace		
	Findings include	:			also respectfully requests		
	8				consideration for paper		
	The elipical reco	ord of Resident B was			compliance for these F tags.		
					F323 483.25(h) FREE OF ACCIDENT		
	reviewed on 7/17				HAZARDS/SUPERVISION/DE	M	
	Diagnoses includ	ded, but were not limited			CES 1. What corrective	. V I	
	to, schizophrenia	n, obsessive-compulsive			action(s) will be accomplishe	d	
	disorders and der	mentia.			for those residents found to I		
					affected by the deficient		
	A quarterly Mini	imum Data Set			practice? The bag of dry dog		
					food was removed from the		
		d 5/24/12, indicated			resident's room on 5/24/2012 a	at	
		a Brief Interview for			0600 by the nursing staff. The		
	Mental Status sc	ore of 10 (moderately			resident's care plan was chang		
	impaired).				to include offering the resident		
					snack foods like cereal or snac		
	A Care Plan date	ed 8/28/11, indicated			crackers to feed her dogs. 2.		
	-	cognitive deficits related			How will you identify other		
		•			residents having the potentia		
	to dementia, mer	nory impairments,			to be affected by these same		
					deficient practice and what		

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Event ID: GQOW11 Facility ID: 000241

If continuation sheet Page 3 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED
		155636				07/18/2012
			B. WING		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R				
LIADDICA					ELLESLEY BLVD	
ПАККІЗ	ON TERRACE			INDIAN	APOLIS, IN 46219	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG		5.112
	impaired decision	on making and poor safety			corrective action will be take	n?
	awareness. App	roaches included, but			An audit was completed on	
	were not limited	to, intervene if resident			7/27/2012 of all residents. This audit was designed to identify	
		safe decision making.			resident with toy pets and eac	
					resident identified had a care	
	A Cara Dlam day	tod 2/20/12 indicated a			written to include offering cere	
		ted 3/20/12, indicated a			or snack crackers to feed the t	
		sident will experience			pet. 3. What measures will b	
		ory hallucinations.			put into place or what systen	nic
	Resident believe	es her stuffed animals are			changes will be made to	
	real, she is marr	ied to superman, has			ensure that the deficient	
	children by him	and that others on the			practice does not recur? All	
	unit are her relat				current facility staff will be offe	red
					education about appropriate	
	A Ossantanles A at	ivity Assassment datad			items that can be given to residents, specifically foods	
		ivity Assessment, dated			designed for human	
	· ·	ed "Resident stated she			consumption. This education v	vill
	would like some	e 'food for her dogs.'"			be added to new employee	
					orientation required for all new	1
	During an interv	view with the			employees. This education wil	l be
	Administrator, o	on 7/17/12 at 4:30 P.M.,			taught by the Staff Developme	
		sident B was given a small			Coordinator and completed by	'
		g food, by the Memory			8/4/2012. 4. How will the	
		for her stuffed toy dogs			corrective action(s) be	
	·				monitored to ensure the	
	and that she had	possibility eaten some.			deficient practice does not recur, i.e. what quality	
					assurance program will be p	ut l
	During an interv	view with the Memory			into place? A CQI Audit Tool,	
	Care Facilitator,	on 7/18/12 at 11:30			Residents with Toy Pets, will be	
	A.M., she indica	ated that during the			used to monitor compliance w	
	quarterly assessi	ment, Resident B had			the Care Plan process and the	
	1 ^	ed real dog food for her			education/orientation process.	
		ld feed them. She (the			This tool will be utilized by the	
	"	· ·			Executive Director/designee to)
	· ·	d for her dogs. The dog			ensure the facility remains in	
		in a small ziploc bag and			compliance with this standard. Audits will be done weekly for	
	~	nt B. This was between			weeks, bi-weekly for two mont	
	1:00 P.M. and 3	:00 P.M. on 5/23/12.			Weeks, or weekly for two filolit	,

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A DUILDING 00		COMPLETED	
	155636	A. BUILDING		07/18/2012	
	100000	B. WING		0111012012	
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE		
			VELLESLEY BLVD		
HARRIS	ON TERRACE	INDIAN	NAPOLIS, IN 46219		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
			monthly for two months, then		
	During an interview with CNA #5, at		quarterly for three quarters.		
			Results of these audits will be	e	
	11:55 A.M., she indicated the Ziploc bag		presented to the CQI Commit	ttee	
	of dog food was found on the bed, next to		each month that audits are		
	the Resident, on 5/24/12 at 6:00 A.M. The		completed to review for		
	bag of dog food was removed from the		compliance and follow-up. Th		
	room and given to Unit Manager #2.		compliance threshold for thes		
	100111 and given to Onit Manager #2.		audits will be 95%. Any thres		
			less than 95% will require that		
	During an interview with Unit Manager		action plan be completed and	1	
	#2, on 7/18/12 at 12:10 P.M., she		implemented. 5. Date of		
	indicated on the morning of 5/24/12 at		compliance: August 4, 2012		
	6:00 A.M., CNA #5 brought her a bag of		F469 483.70(H)(4) MAINTAIN		
			PROGRAM 1. What correct		
	dog food stating a concern that Resident				
	B may have eaten some dog food.		action(s) will be accomplish		
	Nursing staff were unaware the Memory		for those residents found to	be	
	Care Facilitator had given Resident B a		affected by the deficient		
	bag of dog food. The physician was		practice? Steritech treated th	ne	
			entire affected areas on		
	notified. Resident B was not monitored by		7/18/2012 for "small flies". Ar	eas	
	nursing staff regarding the possible		treated included all nursing		
	consumption of dog food while the bag of		stations, pantries, and	iith	
	dog food was in the resident's possession		kitchenettes. In conjunction we the treatment by Steritech, al		
	for 15 hours.		areas were deep cleaned. 2.		
	101 13 Hours.		How will you identify other		
			residents having the potent	ial	
	This federal tag relates to Complaint		to be affected by these sam		
	IN00111520.		deficient practice and what	-	
			corrective action will be tak	on?	
	3.1-45(a)(1)		Steritech treated the entire	UII :	
			affected areas on 7/18/2012	for	
	3.1-45(a)(2)		"small flies". Areas treated		
			included all nursing stations,		
			pantries, and kitchenettes. In		
			conjunction with the treatmen	it by	
			Steritech, all areas were deep		
			cleaned. Daily room rounds		
			conducted Monday through		
			Friday by the management te	eam	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155636	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 07/18/2012
	ROVIDER OR SUPPLIE	R	STREET A 1924 W	ADDRESS, CITY, STATE, ZIP CODE /ELLESLEY BLVD IAPOLIS, IN 46219	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
				include inspection of the nurse stations, pantries, and kitchenettes. Each member of management team will report presents or absence of "small flies" during the 3 o'clock meeting. If "small flies" are no in these areas, Steritech will be notified to retreat the affected area(s). 3. What measures where put into place or what systemic changes will be mattoners end to ensure that the deficient practice does not recur? Dair room rounds conducted Monot through Friday by the management team and on the weekends by the Weekend Manager include inspection or nurses' stations, pantries, and kitchenettes. Each member of management team will report presents or absence of "small flies" during the 3 o'clock meeting. The weekend Management Team on Monday morning. If "small flies" are noted in these areas, Steritech will be notifier retreat the affected area(s). 4 How will the corrective action(s) be monitored to ensure the deficient practice does not recur, i.e. what qual assurance program will be pinto place? A CQI Audit Tool be used to monitor compliance with the "small fly" control plant. This tool will be utilized by the Executive Director/designee to ensure the facility remains fre pests. Audits will be done ween the facility remains fre pests. Audits will be done ween the facility remains fre pests. Audits will be done ween the facility remains fre pests. Audits will be done ween the facility remains fre pests. Audits will be done ween the facility remains fre pests.	fithe the the the ted be vill ade ly lay as fithe the the lifthe the the lifthe the the lifthe lifthe the lifthe lifthe the lifthe l

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Event ID: GQOW11 Facility ID: 000241

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155636	B. WING		07/18/2012
	PROVIDER OR SUPPLIE	R	1924 W	ADDRESS, CITY, STATE, ZIP CODE VELLESLEY BLVD JAPOLIS, IN 46219	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				for four weeks, bi-weekly for to months, monthly for two month then quarterly for three quarterly for three quarterly for these audits will be presented to the CQI Committerly for completed to review for compliance and follow-up. The compliance threshold for these audits will be 95%. Any thresholess than 95% will require that action plan be completed and implemented. 5. Date of compliance: August 4, 2012	wo hs, rs. ee

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Event ID: GQOW11

Facility ID: 000241

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155636	B. WING		07/18/2012
				T ADDRESS, CITY, STATE, ZIP CODE	L
NAME OF I	PROVIDER OR SUPPLIE	R		WELLESLEY BLVD	
пурріє	ON TERRACE			NAPOLIS, IN 46219	
HARRIO	ONTERRACE		INDIA	INAPOLIS, IN 40219	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0469	483.70(h)(4)				
SS=B		FECTIVE PEST CONTROL			
	PROGRAM	maintain an effective pest			
		so that the facility is free of			
	pests and roden				
	•	iew and observation, the	F0469	The creation and submission	of 08/04/2012
		ensure the facility was		this Plan of Correction does n	
	1	2 of 4 resident units		constitute an admission by	
	_	Mapleton Units). This		Harrison Terrace of any	
	· ·	the potential to affect 52		conclusion set forth in the statement of deficiencies, or or	of
	I -	f residents on Brickyard		any violation of regulation.	
	,			Harrison Terrace respectfully	
	•	Units) out of 109 total		requests that this 2567 Plan of	
	residents.			Correction be considered the	
				Letter of Credible Allegation of	
	Findings include	e:		Compliance. Harrison Terrace	9
				also respectfully requests	
	During a tour or	n 7/17/12 at 10:40 A.M.		consideration for paper compliance for these F tags.	
	_	d Unit with Unit Manager		F323 483.25(h) FREE OF	
	1	ats were observed flying		ACCIDENT	
	, ,, ,	ound the covered trash can		HAZARDS/SUPERVISION/DI	EVI
	_			CES 1. What corrective	
		te area. During an		action(s) will be accomplish	ed
		JM #1 at 11:00 A.M., she		for those residents found to	be
	_	are not usually a problem		affected by the deficient	
	but the recent in	ncreases in humidity and		practice? The bag of dry dog	
	temperatures se	emed to attract them, for		food was removed from the resident's room on 5/24/2012	-4
	some reason un	known to her.		0600 by the nursing staff. The	
				resident's care plan was char	
	During a walk t	hrough on 7/17/12 at		to include offering the residen	•
	-			snack foods like cereal or sna	
		he Mapleton Unit in the		crackers to feed her dogs. 2	
		, gnats were observed		How will you identify other	
	surrounding the	• :		residents having the potenti	
	sink/counter are	ea, and floor.		to be affected by these same	e
	Additionally, gr	nats were observed		deficient practice and what	
	hovering over o	pened fruit juices on the		corrective action will be take	en?
1				An audit was completed on	

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Facility ID: 000241

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MU	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
		155636	A. BUIL B. WING			07/18/20	012
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			/ELLESLEY BLVD		
LADDICA	ON TERRACE				IAPOLIS, IN 46219		
ПАККІЗ	JN TERRACE			INDIAN	AFOLIS, IN 40219		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	counter and mo	bile dining cart.			7/27/2012 of all residents. Th		
					audit was designed to identify		
	During a walk t	hrough on 7/17/12 at			resident with toy pets and ead resident identified had a care		
		he Brickyard Unit, gnats			written to include offering cere		
		ng and hovering in the			or snack crackers to feed the		
					pet. 3. What measures will i		
		ind the nurses station.			put into place or what syste		
		erved hovering around the			changes will be made to		
		k and under the sink in the			ensure that the deficient		
	cabinet, too. Di	uring the walk through, an			practice does not recur? All		
interview with RN #3 indicated coffee				current facility staff will be offe	ered		
was made and bread was toasted in the				education about appropriate			
pantry area for residents to consume.				items that can be given to			
					residents, specifically foods designed for human		
	An interview w	as conducted with the			consumption. This education	will	
					be added to new employee	vviii	
		etor (ED) and Director of			orientation required for all nev	w	
	~	es (DNS) on 7/17/12 at			employees. This education w		
	12:40 P.M. The	ey indicated awareness of			taught by the Staff Developm	ent	
	the gnats and th	at the gnats seemed to be			Coordinator and completed b	y	
	a chronic issue.	The ED indicated the			8/4/2012. 4. How will the		
	pest control spe	cialists service was			corrective action(s) be		
		norning and were expected			monitored to ensure the		
		at afternoon or the next			deficient practice does not		
					recur, i.e. what quality assurance program will be p		
		12). The ED and DNS			into place? A CQI Audit Tool		
	00	nats were attracted to sinks			Residents with Toy Pets, will		
		off pouring left over fruit			used to monitor compliance v		
	juices down the	sink as a means to			the Care Plan process and th		
	dispose. They i	ndicated staff were			education/orientation process		
	educated and in	structed to flush sink and			This tool will be utilized by the		
	drain with hot w	vater after the disposal of			Executive Director/designee t	ю	
		indicated the facility had			ensure the facility remains in		
		revention service that			compliance with this standard Audits will be done weekly for		
					weeks, bi-weekly for two mon		
	neated the facili	ity on a monthly basis.			monthly for two months, then	,	
					quarterly for three quarters.		
	This federal tag	relates to Complaint			Results of these audits will be	,	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155636		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/18/2012
	PROVIDER OR SUPPLIER ON TERRACE	1924 W	ADDRESS, CITY, STATE, ZIP CODE /ELLESLEY BLVD IAPOLIS, IN 46219	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	IN00111520. 3.1-19(f)(4)		presented to the CQI Commite each month that audits are completed to review for compliance and follow-up. The compliance threshold for these audits will be 95%. Any threshold less than 95% will require that action plan be completed and implemented. 5. Date of compliance: August 4, 2012 F469 483.70(H)(4) MAINTAIN EFFECTIVE PEST CONTRO PROGRAM 1. What correct action(s) will be accomplish for those residents found to affected by the deficient practice? Steritech treated the entire affected areas on 7/18/2012 for "small flies". Are treated included all nursing stations, pantries, and kitchenettes. In conjunction with the treatment by Steritech, all areas were deep cleaned. 2. How will you identify other residents having the potentit to be affected by these same deficient practice and what corrective action will be take Steritech treated the entire affected areas on 7/18/2012 for "small flies". Areas treated included all nursing stations, pantries, and kitchenettes. In conjunction with the treatment Steritech, all areas were deep cleaned. Daily room rounds conducted Monday through Friday by the management te include inspection of the nurs stations, pantries, and kitchenettes. Each member of the search of the stations, pantries, and kitchenettes. Each member of the stations.	e se hold tan l NS L tive ed be le eas le eas le tive tive tive tive tive tive tive tiv

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	OF OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155636	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 07/18/2012
	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE /ELLESLEY BLVD IAPOLIS, IN 46219	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
				management team will report presents or absence of "sm flies" during the 3 o'clock meeting. If "small flies" are in these areas, Steritech will notified to retreat the affected area(s). 3. What measures be put into place or what systemic changes will be to ensure that the deficient practice does not recur? It room rounds conducted Mothrough Friday by the management team and on tweekends by the Weekend Manager include inspection nurses' stations, pantries, a kitchenettes. Each member management team will report presents or absence of "sm flies" during the 3 o'clock meeting. The weekend Maragement team will report to the Management Team on Monday morning. "small flies" are noted in the areas, Steritech will be notificated the affected area(s). How will the corrective action(s) be monitored to ensure the deficient practice does not recur, i.e. what quasurance program will be into place? A CQI Audit To be used to monitor compliant with the "small fly" control por This tool will be utilized by the Executive Director/designed ensure the facility remains for pests. Audits will be done with for four weeks, bi-weekly for months, monthly for two months, monthly for three quarterly for three quarte	all noted II be ed s will made at Daily notay the and of the and of the all nager ent If ese fied to 4. dice uality e put not will noce clan. che e to free of reekly or two onths,

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155636	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/18/2012
	ROVIDER OR SUPPLIER ON TERRACE	<u> </u>	1924 W	ADDRESS, CITY, STATE, ZIP CODE /ELLESLEY BLVD IAPOLIS, IN 46219	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	Results of these audits will be presented to the CQI Commeach month that audits are completed to review for compliance and follow-up. Tompliance threshold for the audits will be 95%. Any thre less than 95% will require the action plan be completed an implemented. 5. Date of compliance: August 4, 201	che hittee The ese shold eat an

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